House of Representatives

General Assembly

File No. 308

February Session, 2002

Substitute House Bill No. 5154

House of Representatives, April 4, 2002

The Committee on Public Health reported through REP. EBERLE of the 15th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HOSPITAL FINANCE AND DATA REPORTING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2002*) On or before September 1, 2002, and each September first thereafter, each short-term acute care general or children's hospital licensed by the Department of Public Health, shall submit to the Office of Health Care Access, in the form and manner prescribed by the office, the hospital's budget for the next hospital fiscal year. Said budget shall have been approved by the hospital's governing body and shall contain the hospital's budgeted revenue and expenses and utilization amounts for the following fiscal year and any other type of data previously reported as part of the net revenue system contained in sections 19a-674, 19a-675, 19a-676a, 19a-678 and 19a-680 of the general statutes, revision of 1958, revised to January 1, 2001, and any regulations adopted pursuant to said sections, which the office may require.

Sec. 2. Subsection (a) of section 19a-644 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) On or before February twenty-eighth annually, **[**each health care facility and institution for which a budget was approved or revenue limits were established under the provisions of section 19a-640 or section 19a-674,**]** for the fiscal year ending on September thirtieth of the immediately preceding year, each hospital licensed by the Department of Public Health shall report to the office with respect to its operations in such fiscal year, in such form as the office may by regulation require. Any hospital licensed by the Department of Public Health that has a fiscal year that ends on a date other than September thirtieth, shall report to the office with respect to its operations in the immediately preceding fiscal year, on or before the last business day of the fifth month following the close of the hospital fiscal year, in such form as the office may require by regulations adopted by the commissioner in accordance with chapter 54. Said report shall include: (1) Average salaries in each department of administrative personnel, supervisory personnel, and direct service personnel by job classification; (2) salaries and fringe benefits for each of the ten highest paid **[**positions**]** administrators and the ten highest paid clinical professionals by individual position titles; (3) the full legal name of each joint venture, partnership, subsidiary, **[**and**]** parent corporation or other legal entity related to the hospital and an explanation of how the entity is related; and (4) the individual amounts of salaries and fringe benefits, if any, paid to each person in each of the hospital's top ten administrative or clinical positions, listed by hospital position, affiliate name and affiliate position title, by each entity related to the hospital in any way and any amount paid to any other hospital employees by each such joint venture, partnership, subsidiary, **[**and**]** related corporation or entity and by the hospital to the employees of related **[**corporations**]** entities not otherwise reported under this section. In addition, said report may, at the discretion of the office, include a breakdown of hospital and department budgets by administrative, supervisory and direct service categories, by total dollars, by full-time equivalent staff or any combination thereof, which the office may

request at any time of the year, provided the office gives the hospital at least thirty days from the date of the request to provide the information.

Sec. 3. Section 19a-646 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) As used in this section:

(1) "Office" means the Office of Health Care Access;

(2) "Fiscal year" means the hospital fiscal year as used for purposes of this chapter;

(3) "Hospital" means any **[**short-term acute care general**]** hospital licensed by the Department of Public Health in the state;

(4) "Payer" means any person, legal entity, governmental body or eligible organization covered by the provisions of **[**42 USC Section 1395mm(b)**]** Section 1876 of the Social Security Act, or any combination thereof, except for Medicare and Medicaid which is or may become legally responsible, in whole or in part for the payment of services rendered to or on behalf of a patient by a hospital. Payer also includes any legal entity whose membership includes one or more payers and any third-party payer; and

(5) "Prompt payment" means payment made for services to a hospital by mail or other means on or before the tenth business day after receipt of the bill by the payer.

(b) No hospital shall provide a discount or different rate or method of reimbursement from the filed rates or charges to any payer except as provided in this section.

[(c) (1) Until September 30, 1993, in addition to procedures available to other private third-party payers, an eligible organization, as described in 42 USC Section 1395mm(b), may directly negotiate for a different rate and method of reimbursement with a hospital.

(2) Effective October 1, 1993, to March 31, 1994, inclusive, an eligible organization, as described in 42 USC Section 1395mm(b), may directly negotiate for a different rate and method of reimbursement with a hospital provided (A) the cost of such discount is not shifted, in whole or in part, to other payers not so covered by the discount agreement; and (B) the charges and payment for the payer are reported in accordance with this subsection.

(3) On and after April 1, 1994,**]**

(c) (1) From April 1, 1994, to June 30, 2002, any payer may directly negotiate for a different rate and method of reimbursement with a hospital provided the charges and payments for the payer are reported in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement shall be effective until filed with the office.

(2) On and after July 1, 2002, any payer may directly negotiate with a hospital for a different rate or method of reimbursement, or both, provided the charges and payments for the payer are on file at the hospital business office in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement, or both, shall be effective until a complete written agreement between the hospital and the payer is on file at the hospital. Each such agreement shall be available to the office for inspection or submission to the office upon request, for at least three years after the close of the applicable fiscal year.

[(4)**]** (3) On and after April 1, 1994, the charges and payments for each payer receiving a discount shall be accumulated by the hospital for each payer and reported as required by the office. The office may require a review by the hospital's independent auditor, at the hospital's expense, to determine compliance with **[**subdivision (3) of**]** this subsection.

[(5) A**]** (4) From October 2, 1991, to June 30, 2002, a full written copy of each agreement executed pursuant to this subsection **[**, on and after

October 2, 1991,] shall be filed with the Office of Health Care Access by each hospital executing such an agreement, no later than ten business days after such agreement is executed. On and after July 1, 2002, a full written copy of each agreement executed pursuant to this subsection shall be on file in the hospital business office within twenty-four hours of execution. Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection. Agreements filed at the Office of Health Care Access, in accordance with this subsection, shall be considered trade secrets pursuant to subdivision (5) of subsection (b) of section 1-210, as amended, except that the office may utilize and distribute data derived from such agreements, including the names of the parties to the agreement, the duration and dates of the agreement and the estimated value of any discount or alternate rate of payment.

(d) A payer may negotiate with a hospital to obtain a discount on rates or charges for prompt payment.

(e) A payer may also negotiate for and may receive a discount for the provision of the following administrative services: (1) A system which permits the hospital to bill the payer through either a computer-processed or machine-readable or similar billing procedure; (2) a system which enables the hospital to verify coverage of a patient by the payer at the time the service is provided; and (3) a guarantee of payment within the scope of the agreement between the patient and the third-party payer for service to the patient prior to the provision of that service.

(f) No hospital may require a payer to negotiate for another element or any combination of the above elements of a discount, as established in subsections (d) and (e) of this section, in order to negotiate for or obtain a discount for any single element. No hospital may require a payer to negotiate a discount for all patients covered by such payer in order to negotiate a discount for any patient or group of patients covered by such payer.

(g) Any hospital which agrees to provide a discount to a payer under subsection (d) or (e) of this section shall file a copy of the

agreement [with the] in the hospital's business office and shall provide the same discount to any other payer who agrees to make prompt payment or provide administrative services similar to that contained in the agreement. Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection. The office shall disallow any agreement which gives a discount pursuant to the terms of subsections (d) and (e) of this section which is in excess of the maximum amount set forth in said subsections. No such agreement shall be contingent on volume or drafted in such a manner as to limit the discount to one or more payers by establishing criteria unique to such payers. Any payer aggrieved under this subsection may petition the office for an order directing the hospital to provide a similar discount. The office shall adopt regulations in accordance with the provisions of chapter 54 to carry out the provisions of this subsection.

(h) (1) Nothing in this section shall be construed to require payment by any payer or purchaser, under any program or contract for payment or reimbursement of expenses for health care services, for: (A) Services not covered under such program or contract; or (B) that portion of any charge for services furnished by a hospital that exceeds the amount covered by such program or contract.

(2) Nothing in this section shall be construed to supersede or modify any provision of such program or contract that requires payment of a copayment, deductible or enrollment fee or that imposes any similar requirement.

(i) A hospital which has established a program approved by the office with one or more banks for the purpose of reducing the hospital's bad debt load, may reduce its published charges for that portion of a patient's bill for services which a payer who is a private individual is or may become legally responsible for, after all other insurers or third-party payers have been assessed their full charges provided (1) prior to the rendering of such services, the hospital and the individual payer or parent or guardian or custodian have agreed in writing that after receipt of any insurer or third-party payment paid in

accordance with the full hospital charges the remaining payment due from the private individual for such reduced charges shall be made in whole or in part from the balance on deposit in a bank account which has been established by or on behalf of such individual patient, and (2) such payment is made from such account. Nothing in this section shall relieve a patient or legally liable person from being responsible for the full amount of any underpayment of the hospital's authorized charges excluding any discount under this section, by a patient's insurer or any other third-party payer for that insurer's or third-party payer's portion of the bill. Any reduction in charges granted to an individual or parent or guardian or custodian under this subsection shall be reported to the office as a contractual allowance. For purposes of this section "private individual" shall include a patient's parent, legal guardian or legal custodian but shall not include an insurer or third-party payer.

Sec. 4. Section 19a-654 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

The Office of Health Care Access shall require hospitals to submit such data, including discharge data, as it deems necessary **[**for budget review purposes**]** to fulfill the responsibilities of the office. Such data shall include data taken from medical record abstracts and hospital bills. The timing and format of such submission shall be specified by the office. The data may be submitted through a contractual arrangement with an intermediary. If the data is submitted through an intermediary, the hospital shall ensure that such submission is timely and that the data is accurate. The office may conduct an audit of the data submitted to such intermediary in order to verify its accuracy. Individual patient and physician data identified by proper name or personal identification code submitted pursuant to this section shall be kept confidential, but aggregate reports from which individual patient and physician data cannot be identified shall be available to the public.

Sec. 5. Section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

As used in sections 19a-659, as amended by this act, **[**to 19a-662,

inclusive,] 19a-661, 19a-662, 19a-669 to 19a-672, inclusive, as amended by this act, [and 19a-674 to 19a-680, inclusive] 19a-676, 19a-677 and 19a-679:

(1) "Office" means the Office of Health Care Access;

(2) "Hospital" means a hospital included within the definition of health care facilities or institutions under section 19a-630 and licensed as a short-term general hospital by the Department of Public Health and including John Dempsey Hospital of The University of Connecticut Health Center;

(3) "Fiscal year" means the hospital fiscal year;

(4) "Base year" means the fiscal year prior to the fiscal year for which a budget is being determined;

(5) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization;

(6) "Uncompensated care including emergency assistance to families" means the actual cost in the year prior to the base year of care written off as bad debts or provided free under a free care policy approved by the office including emergency assistance to families authorized by the Department of Social Services and not otherwise funded;

(7) "Medical assistance" means medical assistance provided under the general assistance program, the state-administered general assistance program or the Medicaid program;

(8) "CHAMPUS" means TriCare or the federal Civilian Health and Medical Program of the Uniformed Services, 10 USC 1071 et seq.;

(9) "Medicare shortfall" means the Medicare underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and

uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(10) "Medical assistance shortfall" means the medical assistance underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(11) "CHAMPUS shortfall" means the CHAMPUS underpayment for the year prior to the base year divided by the proportion of total charges excluding Medicare, medical assistance, CHAMPUS, and uncompensated care including emergency assistance to families and contractual and other allowances for the year prior to the base year;

(12) "Primary payer" means the payer responsible for the highest percentage of the charges on the case;

(13) "Case mix index" means a hospital's case mix index calculated using the medical record abstract and billing data submitted by the hospital to the office. The case mix index shall be calculated by dividing the total case mix adjusted discharges for the hospital by the actual number of discharges for the hospital for the fiscal year. The total case mix adjusted discharges shall be calculated by multiplying the number of discharges in each diagnosis related group by the Medicare weights in effect for the same diagnosis related group in effect for the fiscal year and adding the resultant procedures across all diagnosis related groups;

(14) "Contractual allowances" means, for the period October 1, 1992, to March 30, 1994, inclusive, the amount of discounts provided to nongovernmental payers pursuant to subsections (d) and (e) of section 19a-646, as amended by this act, **[**and**]** for the period beginning April 1, 1994, the amount of discounts provided to nongovernmental payers pursuant to subsections (c), (d) and (e) of section 19a-646, as amended by this act, and on and after July 1, 2002, any amount of discounts

provided to nongovernmental payers pursuant to a written agreement;

(15) "Medicare underpayment" means the difference between the actual net revenue of a hospital times the ratio of Medicare charges to total charges and the amount received by the hospital from the federal government for Medicare patients for the year prior to the base year;

(16) "Medical assistance underpayment" means the difference between the actual net revenue of a hospital times the ratio of medical assistance charges to total charges and the amount received by the hospital from the Department of Social Services for the year prior to the base year;

(17) "CHAMPUS underpayment" means the difference between the actual net revenue of a hospital times the ratio of CHAMPUS charges to total charges and the amount received by the hospital from CHAMPUS for the year prior to the base year;

(18) "Other allowances" means the amount of any difference between charges for employee self-insurance and related expenses determined using the hospital's overall relationship of costs to charges;

(19) "Gross revenue" means the total charges for all patient care services;

(20) "Net revenue" means total gross revenue less contractual allowance, the difference between government charges and government payments, uncompensated care, and other allowances; plus, for purposes of compliance, net payments from the uncompensated care pool in existence prior to April 1, 1994, and payments from the Department of Social Services;

(21) "Emergency assistance to families" means assistance to families with children under the age of twenty-one who do not have the resources to independently provide the assistance needed to avoid the destitution of the child and which is authorized by the Department of Social Services pursuant to section 17b-107 and is not otherwise funded.

Sec. 6. Section 19a-668 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

Notwithstanding section 19a-667, the Office of Health Care Access may maintain or enter into any contract or contracts with one or more private entities within available appropriations to deactivate, audit or consult on any rights, duties or obligations owed to the uncompensated care pool prior to April 1, 1994, to assist the Department of Social Services and to assist in the administration of sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, as amended, subsection (1) of section 12-408, as amended, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414, and sections 19a-646, as amended by this act, 19a-659, as amended by this act, **[**to 19a-662, inclusive, and**]** 19a-661, 19a-662, 19a-666 to **[**19a-680**]** 19a-673, inclusive, as amended by this act, 19a-676, 19a-677 and 19a-679 on or after April 1, 1994.

Sec. 7. Section 19a-669 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

Effective October 1, 1993, and October first of each subsequent year, the Secretary of the Office of Policy and Management shall determine and inform the Office of Health Care Access of the maximum amount of disproportionate share payments and emergency assistance to families eligible for federal matching payments under the Medical Assistance Program or the Emergency Assistance to Families Program pursuant to federal statute and regulations and subdivisions (2) and (28) of section 12-407, as amended, subsection (1) of section 12-408, as amended, subdivision (5) of section 12-412, section 12-414, sections 19a-649 **[**, 19a-660**]** and 19a-661 and this section and the actual and anticipated appropriation to the medical assistance disproportionate share-emergency assistance account authorized pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, as amended, subsection (1) of section 12-408, as amended, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-

659, as amended by this act, [to 19a-662, inclusive, and] 19a-661, 19a-662, 19a-666 to [19a-680] 19a-673, inclusive, as amended by this act, sections 19a-676, 19a-677 and 19a-679 and the amount of emergency assistance to families' payments to eligible hospitals projected for the year, and the anticipated amount of any increase in payments made pursuant to any resolution of any civil action pending on April 1, 1994, in the United States district court for the district of Connecticut. The Department of Social Services shall inform the office of any amount of uncompensated care which the Department of Social Services determines is due to a failure on the part of the hospital to register patients for emergency assistance to families, or a failure to bill properly for emergency assistance to families' patients. If during the course of a fiscal year the Secretary of the Office of Policy and Management determines that these amounts should be revised, he shall so notify the office and the office may modify its calculation pursuant to section 19a-671, as amended by this act, to reflect such revision and its orders [in accordance with section 19a-660,] as it deems appropriate and the Commissioner of Social Services may modify his determination pursuant to section 19a-671, as amended by this act.

Sec. 8. Subsection (d) of section 19a-670 of the general statutes, as amended by section 3 of public act 01-3 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(d) Nothing in section 3-114i, subdivisions (2) or (29) of section 12-407, as amended, subsection (1) of section 12-408, as amended, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414, or sections 12-263a to 12-263e, inclusive, sections 19a-646, as amended by this act, 19a-659, as amended by this act, [to 19a-662,] 19a-661, 19a-662 or 19a-666 [to 19a-680, inclusive,] to 19a-673, inclusive, as amended by this act, sections 19a-676, 19a-677 or 19a-679 or sections 1, 2, or 38 of public act 94-9* shall be construed to require the Department of Social Services to pay out more funds than are appropriated pursuant to said sections.

Sec. 9. Section 19a-670b of the general statutes, as amended by section 67 of public act 01-2 of the June special session and sections 129 and 130 of public act 01-9 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

Nothing in section 12-263a, subsection (28) of section 12-407, section 19a-670, as amended by this act, or section 19a-670a **[**or 19a-676a**]** shall be construed as relieving any children's general hospital from any prior year's disproportionate share settlements or adjustments.

Sec. 10. Section 19a-671 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

The Commissioner of Social Services is authorized to determine the amount of payments pursuant to sections 19a-670 to 19a-672, inclusive, as amended by this act, for each hospital. The commissioner's determination shall be based on the advice of the office and the application of the calculation in this section. For each hospital, the Office of Health Care Access shall calculate the amount of payments to be made pursuant to sections 19a-670 to 19a-672, inclusive, as amended by this act, as follows:

(1) For the period April 1, 1994, to June 30, 1994, inclusive, and for the period July 1, 1994, to September 30, 1994, inclusive, the office shall calculate and advise the Commissioner of Social Services of the amount of payments to be made to each hospital as follows:

(A) Determine the amount of pool payments for the hospital, including grants approved pursuant to section 19a-168k, in the previously authorized budget authorization for the fiscal year commencing October 1, 1993.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation to the medical assistance disproportionate share-emergency assistance account made pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, as amended, subsection (1) of section 12-408, as amended, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-659, as amended by this act, [to 19a-662, inclusive,] 19a-661, 19a-662 and 19a-666 to [19a-680, inclusive,] 19a-673, inclusive, as amended by this act, 19a-673, 19a-676, 19a-677 and 19a-679 for the quarter subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract the amount of any emergency assistance to families payments projected by the office to be made to hospitals in the quarter.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

(2) For the fiscal year commencing October 1, 1994, and subsequent fiscal years, the interim payment shall be calculated as follows for each hospital:

(A) For each hospital determine the amount of the medical assistance underpayment determined pursuant to section 19a-659, as amended by this act, plus the actual amount of uncompensated care including emergency assistance to families determined pursuant to section 19a-659, as amended by this act, less any amount of uncompensated care determined by the Department of Social Services to be due to a failure of the hospital to enroll patients for emergency assistance to families, plus the amount of any grants authorized pursuant to the authority of section 19a-168k.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation made to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, as amended, subsection (1) of section 12-408, as amended, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, 19a-659, **[**to 19a-662, inclusive, **]** 19a-661, 19a-662 and 19a-666 **[**to 19a-680, inclusive,**]** to 19a-673, inclusive, 19a-676, 19a-677 and 19a-679, as amended by this act, for the fiscal year, subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract any emergency assistance to families payments projected by the office to be made to the hospitals for the year.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

Sec. 11. Section 19a-672 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

The funds appropriated to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, as amended, subsection (1) of section 12-408, as amended, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-659, as amended by this act, **[**to 19a-662, inclusive, and**]** 19a-661, 19a-662, 19a-666 to **[**19a-680, inclusive,**]** 19a-673, inclusive, as amended by this act, 19a-676, 19a-677 and 19a-679 shall be used by said account to make disproportionate share payments to hospitals, including grants to hospitals pursuant to section 19a-168k, and to make emergency

assistance to families payments to hospitals. In addition, the medical assistance disproportionate share-emergency assistance account may utilize a portion of these funds to make outpatient payments as the Department of Social Services determines appropriate or to increase the standard medical assistance payments to hospitals if the Department of Social Services determines it to be appropriate to settle any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut. Notwithstanding any other provision of the general statutes, the Department of Social Services shall not be required to make any payments pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of section 12-407, as amended, subsection (1) of section 12-408, as amended, section 12-408a, subdivision (5) of section 12-412, subsection (1) of section 12-414 and sections 19a-646, as amended by this act, 19a-659, as amended by this act, **[**to 19a-662, inclusive,**]** 19a-661, 19a-662 and 19a-666 to **[**19a-680, inclusive,**]** 19a-673, inclusive, as amended by this act, 19a-676, 19a-677 and 19a-679 in excess of the funds available in the medical assistance disproportionate share-emergency assistance account.

Sec. 12. Subsection (a) of section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and homemaker-home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. For the period from February 1, 1991, to January 31, 1992, inclusive, payment for each service to the state shall be based upon the rate for such service as determined by the Office of Health Care Access, except that for those providers whose Medicaid rates for the year ending January 31, 1991, exceed the median rate, no increase shall be allowed. For those providers whose rates for the year ending January 31, 1991, are below the median rate, increases shall not exceed the lower of the prior rate increased by the most recent annual increase in the consumer price index for urban

consumers or the median rate. In no case shall any such rate exceed the eightieth percentile of rates in effect January 31, 1991, nor shall any rate exceed the charge to the general public for similar services. Rates effective February 1, 1992, shall be based upon rates as determined by the Office of Health Care Access, except that increases shall not exceed the prior year's rate increased by the most recent annual increase in the consumer price index for urban consumers and rates effective February 1, 1992, shall remain in effect through June 30, 1993. Rates effective July 1, 1993, shall be based upon rates as determined by the Office of Health Care Access **[**pursuant to the provisions of subsection (b) of section 19a-635,**]** except if the Medicaid rates for any service for the period ending June 30, 1993, exceed the median rate for such service, the increase effective July 1, 1993, shall not exceed one per cent. If the Medicaid rate for any service for the period ending June 30, 1993, is below the median rate, the increase effective July 1, 1993, shall not exceed the lower of the prior rate increased by one and one-half times the most recent annual increase in the consumer price index for urban consumers or the median rate plus one per cent. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually increase any fee in the fee schedule based on an increase in the cost of services. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, as amended, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. The commissioner may increase any fee payable to a home health care agency or homemaker-home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3) escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or homemaker-home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of

receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months.

Sec. 13. Subsection (a) of section 19a-1c of the general statutes, as amended by section 29 of public act 01-163, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) Whenever the words "Commissioner of Public Health and Addiction Services" are used or referred to in the following sections of the general statutes, the words "Commissioner of Public Health" shall be substituted in lieu thereof and whenever the words "Department of Public Health and Addiction Services" are used or referred to in the following sections of the general statutes, the words "Department of Public Health" shall be substituted in lieu thereof: 1-21b, 2-20a, 3-129, 4-5, 4-38c, 4-60i, 4-67e, 4a-12, 4a-16, as amended, 4a-51, 5-169, 7-22a, 7-42, as amended, 7-44, as amended, 7-45, as amended, 7-48, as amended, 7-49, 7-51, as amended, 7-52, as amended, 7-53, as amended, 7-54, 7-55, 7-59, 7-60, 7-62a, 7-62b, as amended, 7-62c, 7-65, 7-70, as amended, 7-72, 7-73, as amended, 7-74, as amended, 7-127e, 7-504, 7-536, as amended, 8-159a, 8-206d, 8-210, 10-19, 10-71, 10-76d, as amended, 10-203, 10-204a, 10-207, 10-212, as amended, 10-212a, 10-214, 10-215d, 10-253, 10-282, as amended, 10-284, 10-292, as amended, 10a-132, 10a-155, 10a-162a, 12-62f, 12-263a, 12-407, as amended, 12-634, 13a-175b, 13a-175ee, 13b-38n, 14-227a, as amended, 14-227c, 15-121, 15-140r, 15-140u, 16-19z, 16-32e, 16-43, as amended, 16-50c, as amended,

16-50d, 16-50j, 16-261a, 16-262l, 16-262m, 16-262n, 16-262o, 16-262q, 16a-36, 16a-36a, 16a-103, 17-585, 17a-20, 17a-52, 17a-154, 17a-219c, as amended, 17a-220, as amended, 17a-277, as amended, 17a-509, 17a-688, 17b-6, 17b-99, 17b-225, 17b-234, 17b-265, 17b-288, 17b-340, as amended, 17b-341, 17b-347, 17b-350, 17b-351, 17b-354, as amended, 17b-357, 17b-358, 17b-406, 17b-408, 17b-420, 17b-552, 17b-611, 17b-733, as amended, 17b-737, 17b-748, 17b-803, 17b-808, 17b-851a, 19a-1d, 19a-4i, 19a-6, 19a-6a, 19a-7b, as amended, 19a-7c, 19a-7d, as amended, 19a-7e, 19a-7f, 19a-7g, 19a-7h, 19a-9, 19a-10, 19a-13, 19a-14, as amended, 19a-14a, 19a-14b, 19a-15, 19a-17, 19a-17a, 19a-17m, 19a-17n, 19a-19, 19a-20, 19a-21, 19a-23, 19a-24, 19a-25, 19a-25a, 19a-26, 19a-27, 19a-29, 19a-29a, 19a-30, 19a-30a, 19a-32, 19a-32a, 19a-33, 19a-34, 19a-35, 19a-36, 19a-36a, 19a-37, 19a-37a, 19a-37b, 19a-40, as amended, 19a-41, as amended, 19a-42, as amended, 19a-43, 19a-44, 19a-45, as amended, 19a-47, 19a-48, 19a-49, 19a-50, 19a-51, 19a-52, 19a-53, 19a-54, 19a-55, 19a-56a, 19a-56b, 19a-57, 19a-58, 19a-59, 19a-59a, 19a-59b, 19a-59c, 19a-59d, 19a-60, 19a-61, 19a-69, 19a-70, 19a-71, 19a-72, 19a-73, as amended, 19a-74, 19a-75, 19a-76, 19a-79, as amended, 19a-80, as amended, 19a-82 to 19a-91, inclusive, as amended, 19a-92a, 19a-93, 19a-94, 19a-94a, 19a-102a, 19a-103, 19a-104, 19a-105, 19a-108, 19a-109, 19a-110, 19a-110a, 19a-111, 19a-111a, 19a-111e, 19a-112a, 19a-112b, 19a-112c, 19a-113, 19a-113a, 19a-115, 19a-116, 19a-121, 19a-121a, 19a-121b, 19a-121c, 19a-121d, 19a-121e, 19a-121f, 19a-122b, 19a-123d, 19a-124, 19a-125, 19a-148, 19a-175, 19a-176, as amended, 19a-178, 19a-179, as amended, 19a-180, 19a-181a, 19a-182, 19a-183, 19a-184, 19a-186, 19a-187, 19a-195a, 19a-200, 19a-201, 19a-202, 19a-204, 19a-207, 19a-208, 19a-215, 19a-219, 19a-221, 19a-223, 19a-229, 19a-241, 19a-242, 19a-243, 19a-244, 19a-245, 19a-250, 19a-252, 19a-253, 19a-255, 19a-257, 19a-262, 19a-269, 19a-270, 19a-270a, 19a-279l, 19a-310, 19a-311, 19a-312, 19a-313, 19a-320, as amended, 19a-323, 19a-329, 19a-330, 19a-331, 19a-332, 19a-332a, 19a-333, 19a-341, 19a-401, as amended, 19a-402, 19a-406, 19a-409, 19a-420, as amended, 19a-421, as amended, 19a-422, as amended, 19a-423, as amended, 19a-424, as amended, 19a-425, 19a-426, as amended, 19a-427, 19a-428, as amended, 19a-490, as amended, 19a-490c, 19a-490d, as amended, 19a-490e, 19a-490g, 19a-491, 19a-491a, as amended, 19a-491b, as amended, 19a-492, as amended,

19a-493, 19a-493a, 19a-494, 19a-494a, 19a-495, as amended, 19a-496, as amended, 19a-497, as amended, 19a-499, as amended, 19a-500, 19a-501, 19a-503, 19a-504, as amended, 19a-504c, 19a-505, 19a-506, 19a-507a, 19a-507b, 19a-507c, 19a-507d, 19a-508, 19a-509a, 19a-512, 19a-514, 19a-515, 19a-517, 19a-518, 19a-519, 19a-520, 19a-521, 19a-521a, 19a-523, 19a-524, 19a-526, 19a-527, 19a-528, as amended, 19a-530, 19a-531, 19a-533, 19a-534a, as amended, 19a-535, 19a-535a, 19a-536, 19a-537, as amended, 19a-538, 19a-540, 19a-542, 19a-547, 19a-550, as amended, 19a-551, 19a-554, 19a-581, 19a-582, 19a-584, 19a-586, 19a-630, 19a-631, 19a-634, 19a-637, 19a-638, 19a-639, 19a-645, 19a-646, as amended by this act, 19a-663, 19a-673, **[**19a-675,**]** 20-8, 20-8a, 20-9, 20-10, 20-11, 20-11a, 20-11b, 20-12, 20-12a, 20-13, 20-13a, 20-13b, 20-13d, 20-13e, 20-14, 20-14j, 20-27, 20-28a, 20-28b, 20-29, 20-37, 20-39a, 20-40, 20-45, 20-54, 20-55, 20-57, 20-58a, 20-59, 20-66, 20-68, 20-70, 20-71, 20-73, 20-73a, 20-74, 20-74a, 20-74i, 20-74aa, 20-74dd, 20-86b, 20-86c, 20-86d, 20-86f, 20-86h, 20-90, 20-92, 20-93, 20-94, 20-94a, 20-96, 20-97, 20-99, 20-99a, 20-101a, 20-102aa to 20-102ee, inclusive, 20-103a, 20-106, 20-107, 20-108, 20-109, 20-110, 20-114, 20-122a, 20-122b, 20-122c, 20-123a, 20-126b, 20-126h, 20-126j, 20-126k, 20-126l, as amended, 20-126o, 20-126p, 20-126q, 20-126r, 20-126u, 20-127, 20-128a, 20-129, 20-130, 20-133, 20-138a, 20-138c, 20-139a, 20-140a, 20-141, 20-143, 20-146, 20-146a, 20-149, 20-153, 20-154, 20-162n, 20-162p, 20-188, 20-189, 20-190, as amended, 20-192, 20-193, 20-195a, 20-195m, 20-195p, 20-196, 20-198, 20-199, 20-200, 20-202, 20-206, 20-206a, 20-206m, 20-206p, 20-207, 20-211, 20-212, 20-213, 20-214, 20-217, 20-218, 20-220, 20-221, 20-222, 20-222a, 20-223, 20-224, 20-226, 20-227, 20-228, 20-229, 20-231, 20-235a, 20-236, 20-238, 20-241, as amended, 20-242, 20-243, 20-247, 20-250, as amended, 20-252, as amended, 20-252a, 20-255a, 20-256, 20-258, as amended, 20-262, 20-263, as amended, 20-267, as amended, 20-268, as amended, 20-269, as amended, 20-271, as amended, 20-272, 20-341d, 20-341e, 20-341f, 20-341g, 20-341m, 20-358, 20-361, 20-365, 20-396, 20-402, 20-404, 20-406, 20-408, 20-416, 20-474 to 20-476, inclusive, 20-571, 20-578, 21-7, 21a-11, 21a-86a, 21a-86c, 21a-116, 21a-138, 21a-150, 21a-150a, 21a-150b, 21a-150c, 21a-150d, 21a-150f, 21a-150j, 21a-240, 21a-249, 21a-260, 21a-274, 21a-283, 22-6f, 22-6g, 22-6i, 22-131, 22-150, 22-152, 22-165, 22-332b, 22-344, as amended, 22-358, 22a-29,

22a-54, 22a-65, 22a-66a, 22a-66l, 22a-66z, 22a-115, 22a-119, 22a-134g, 22a-134bb, 22a-137, 22a-163a, 22a-163i, 22a-176, 22a-191, 22a-192, 22a-208q, 22a-231, 22a-240, 22a-240a, 22a-295, 22a-300, 22a-308, 22a-337, 22a-352, 22a-354i, 22a-354k, 22a-354w, 22a-354x, 22a-354aa, 22a-355, 22a-356, 22a-358, 22a-361, 22a-363b, as amended, 22a-371, 22a-378, 22a-423, 22a-424, 22a-426, 22a-430, 22a-434a, 22a-449i, 22a-471, 22a-474, 22a-601, 25-32, as amended, 25-32b, 25-32c, 25-32d, 25-32e, as amended, 25-32f, 25-32g, as amended, 25-32h, 25-32i, 25-32k, as amended, 25-32l, 25-33, 25-33a, 25-33c, 25-33d, 25-33e, 25-33f, 25-33g, 25-33h, 25-33i, 25-33j, 25-33k, 25-33l, 25-33n, 25-34, 25-35, 25-36, as amended, 25-37a, 25-37b, 25-37c, 25-37d, 25-37e, 25-37f, 25-37g, 25-39a, 25-39b, 25-39c, 25-40, 25-43b, 25-43c, 25-46, 25-49, 25-102gg, 25-128, 25-129, 25-137, 26-22, 26-119, 26-141b, 26-192a, 26-192b, 26-192c, 26-192e, 26-236, 27-140aa, 31-23, 31-40u, 31-51u, 31-101, 31-106, 31-111a, 31-111b, 31-121a, 31-222, as amended, 31-374, 31-397, 31-398, 31-400, 31-401, 31-402, 31-403, 32-23x, 38a-180, 38a-199, 38a-214, 38a-514, 38a-583, 45a-743, 45a-745, 45a-749, 45a-750, as amended, 45a-757, 46a-28, 46a-126, 46b-26, 46b-172a, 47a-52, 52-146f, 52-146k, 52-473a, 52-557b, as amended, 53-332, 54-102a, 54-102b, 54-142k, 54-203.

Sec. 14. Subsection (a) of section 19a-612c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) On and after July 1, 1995, wherever the word "commission" is used or referred to in the following sections of the general statutes, the word "office" shall be substituted in lieu thereof and whenever the words "Commission on Hospitals and Health Care" are used or referred to in the following sections of the general statutes, the words "Office of Health Care Access" shall be substituted in lieu thereof: 1-84, 1-84b, 12-263a, 17a-678, 17b-234, 17b-240, 17b-352, 17b-353, 17b-356, 19a-499, 19a-507, 19a-509b, 19a-535b, 19a-633, **[**19a-635, 19a-636,**]** 19a-638 to 19a-650, inclusive, 19a-653, 19a-654, **[**19a-660 to**]** 19a-661, 19a-662, **[**inclusive,**]** 19a-669 to 19a-671, inclusive, as amended by this act, **[**19a-674 to 19a-679, inclusive**]** 19a-676, 19a-677 and 19a-679.

Sec. 15. Section 19a-637 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) In any of its deliberations involving a proposal, request or submission regarding rates or services by a health care facility or institution, the office shall take into consideration and make written findings concerning each of the following principles and guidelines: The relationship of the proposal, request or submission to the state health plan; the relationship of the proposal, request or submission to the applicant's long-range plan; the financial feasibility of the proposal, request or submission and its impact on the applicant's rates and financial condition; the impact of such proposal, request or submission on the interests of consumers of health care services and the payers for such services; the contribution of such proposal, request or submission to the quality, accessibility and cost-effectiveness of health care delivery in the region; whether there is a clear public need for any proposal or request; whether the health care facility or institution is competent to provide efficient and adequate service to the public in that such health care facility or institution is technically, financially and managerially expert and efficient; that rates be sufficient to allow the health care facility or institution to cover its reasonable capital and operating costs; the relationship of any proposed change to the applicant's current utilization statistics; the teaching and research responsibilities of the applicant; the special characteristics of the patient-physician mix of the applicant; the voluntary efforts of the applicant in improving productivity and containing costs; and any other factors which the office deems relevant, including, in the case of a facility or institution as defined in subsection (c) of section 19a-490, such factors as, but not limited to, the business interests of all owners, partners, associates, incorporators, directors, sponsors, stockholders and operators and the personal backgrounds of such persons. Whenever the granting, modification or denial of a request is inconsistent with the state health plan, a written explanation of the reasons for the inconsistency shall be included in the decision.

(b) Any data submitted to or obtained or compiled by the office

with respect to its deliberations under sections [19a-635] 19a-637 to 19a-640, inclusive, with respect to nursing homes, licensed under chapter 368v, shall be made available to the Department of Public Health.

(c) Notwithstanding the provisions of subsection (a) of this section, the office in its deliberations under section [19a-635, 19a-636 or] 19a-640, shall not direct or control the use of the following resources of the hospital concerned: The principal and all income from restricted and unrestricted grants, gifts, contributions, bequests and endowments.

Sec. 16. Section 19a-656 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) For the fiscal year commencing October 1, 1991, the compliance assessment to be applied in the year commencing October 1, 1993, shall be calculated as follows:

(1) Subtract the authorized net revenue per equivalent discharge for the hospital from the actual net revenue per equivalent discharge for the hospital plus any discounts provided by the hospital pursuant to subsection (c) of section 19a-646, as amended by this act.

(2) Multiply the result of subdivision (1) of this subsection by the actual number of equivalent discharges. If the result is positive, it is the net revenue compliance adjustment, otherwise the net revenue compliance adjustment is zero.

(3) Multiply the result of subdivision (2) of this subsection by the ratio of authorized gross revenue prior to any uncompensated care pool adjustment to authorized net revenue for the year commencing October 1, 1991. The result shall be the gross revenue compliance adjustment.

(4) The total amount of the net revenue compliance adjustment calculated in subdivision (2) of this subsection shall be applied in the fiscal year commencing October 1, 1993, except that if the result of subdivision (2) of this subsection is greater than three and one-fourth

per cent of the authorized net revenue for the fiscal year commencing October 1, 1992, the amount of net revenue compliance to be taken in the fiscal year commencing October 1, 1993, shall be three and one-fourth per cent of the authorized net revenue for the fiscal year commencing October 1, 1992.

(5) The total amount of the gross revenue compliance adjustment calculated in subdivision (3) of this subsection shall be applied in the fiscal year commencing October 1, 1993, except that if the result of subdivision (3) of this subsection is greater than four and one-fourth per cent of the authorized gross revenue for the fiscal year commencing October 1, 1992, the amount of gross revenue compliance to be taken in the fiscal year commencing October 1, 1993, shall be four and one-fourth per cent of the authorized gross revenue for the fiscal year commencing October 1, 1992.

(b) Any net or gross revenue compliance determined for the year commencing October 1, 1991, pursuant to section 19a-167g-82 of the regulations of Connecticut state agencies, as amended from time to time, which is not assessed pursuant to subdivisions (4) and (5) of subsection (a) of this section shall be forgiven by the office.

(c) The balance of the compliance adjustments calculated by the office for the fiscal year commencing October 1, 1989, but not assessed shall be forgiven by the office.

[(d) The compliance adjusted net revenue, prior to the uncompensated care pool adjustments, for the year commencing October 1, 1993, shall be the result of subdivision (4) of section 19a-655 less the net revenue compliance adjustment to be assessed in the fiscal year commencing October 1, 1993, calculated in subdivision (4) of subsection (a) of this section if such compliance adjustment is a positive number. The compliance adjusted net revenue cap for the year commencing October 1, 1993, shall be the compliance adjusted net revenue divided by the authorized equivalent discharges for the fiscal year commencing October 1, 1993.

(e) The compliance adjusted gross revenue, prior to the uncompensated care pool adjustments, for the year commencing October 1, 1993, shall be the result of subdivision (5) of section 19a-655 less the gross revenue compliance adjustment to be assessed in the fiscal year commencing October 1, 1993, calculated in subdivision (5) of subsection (a) of this section if such compliance adjustment is a positive number. The compliance adjusted gross revenue cap prior to the uncompensated care pool adjustments for the year commencing October 1, 1993, shall be the compliance adjusted gross revenue prior to the uncompensated care pool adjustments divided by the authorized equivalent discharges for the fiscal year commencing October 1, 1993.**]**

Sec. 17. Section 19a-657 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) A hospital may request an adjustment to its authorized net and gross revenue and authorized equivalent discharges for the fiscal year commencing October 1, 1993, calculated pursuant to **[**sections 19a-655 and 19a-656**]** section 19a-656, as amended by this act, if it has a certificate of need project which was approved on or before April 26, 1993, which has not already been included in the authorized revenue of the hospital and for which the hospital's certificate of need approval decision indicated that the hospital may request such an adjustment. If there is an agreed upon adjustment, that adjustment shall be made. Any request for recognition of incremental expenses or revenues pursuant to this section shall be received in writing within ten business days following the receipt by the hospital of its authorized revenue caps determined pursuant to **[**sections 19a-655 and 19a-656**]** section 19a-656, as amended by this act. The hospital shall provide such data and support for its request as shall be required by the office, including, but not limited to, the incremental costs and volumes associated with the project. The office may approve, modify or deny such request.

(b) A hospital may request an adjustment to its authorized gross revenue for the fiscal year commencing October 1, 1993, to recognize

additional gross revenue requirements resulting from a change in the wage index due to a Medicare geographic wage index reclassification into urban New York received for the fiscal year commencing October 1, 1992, but not for the fiscal year commencing October 1, 1993, provided:

(1) The failure to obtain a favorable reclassification for the year commencing October 1, 1993, shall not be due to the failure of the hospital to request such reclassification in a timely manner, except where the reclassification was made in error;

(2) The hospital's request has been denied;

(3) The requested incremental gross revenue adjustment for the fiscal year commencing October 1, 1993, shall not exceed the amount of incremental gross revenue the hospital would have received in its authorization for the fiscal year commencing October 1, 1992, after compliance and prior to any uncompensated care pool adjustments, if the hospital had not been granted a change in the Medicare wage index due to geographic reclassification times 1.0425;

(4) Any hospital requesting an adjustment under this subsection shall file at the office documentation and data which demonstrates qualifications under and compliance with subdivisions (1) to (3), inclusive, of this subsection, within ten business days following receipt by the hospital of its authorized revenue caps determined in accordance with **[**sections 19a-655 and 19a-656**]** section 19a-656, as amended by this act. The office may approve, modify or deny a hospital's request under this section.

Sec. 18. Subsection (a) of section 19a-658 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2002*):

(a) Any hospital may, in accordance with this section and **[**sections 19a-655 to 19a-657, inclusive, 19a-664 and 19a-665,**]** sections 19a-656 and 19a-657, as amended by this act, request a one-time adjustment to

its pricemaster in its budget request for the fiscal year commencing October 1, 1993. Such hospital shall submit the actual data required by the office for such adjustment on a computer disk in a format to be specified by the office as follows: (1) A description of the applicable units and the number of inpatient and outpatient units for each item on its pricemaster; (2) the price or charges, including a description and item code number, for each item in its pricemaster and the time period or volume for which each price was applicable; (3) the total gross revenue for each item in its pricemaster; (4) the number of discharges; (5) the number of governmental and nongovernmental units for each item in the pricemaster.

Sec. 19. (*Effective July 1, 2002*) Sections 19a-635, 19a-636, 19a-655, 19a-660, 19a-664, 19a-665, 19a-674, 19a-675, 19a-676a, 19a-678 and 19a-680 of the general statutes are repealed.

This act shall take effect as follows:	
Section 1	*July 1, 2002*
Sec. 2	*July 1, 2002*
Sec. 3	*July 1, 2002*
Sec. 4	*July 1, 2002*
Sec. 5	*July 1, 2002*
Sec. 6	*July 1, 2002*
Sec. 7	*July 1, 2002*
Sec. 8	*July 1, 2002*
Sec. 9	*July 1, 2002*
Sec. 10	*July 1, 2002*
Sec. 11	*July 1, 2002*
Sec. 12	*July 1, 2002*
Sec. 13	*July 1, 2002*
Sec. 14	*July 1, 2002*
Sec. 15	*July 1, 2002*
Sec. 16	*July 1, 2002*
Sec. 17	*July 1, 2002*
Sec. 18	*July 1, 2002*
Sec. 19	*July 1, 2002*

PH *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill contains changes to the Office of Health Care Access' (OHCA) data reporting protocols for acute care hospitals, repeals obsolete statutory references and makes other technical changes which will result in no anticipated fiscal impact for either OHCA or the University of Connecticut Health Center.

Requiring specialty hospitals to submit financial, utilization and patient demographic information to OHCA will enhance the agency's ability to perform health care analyses and will result in no associated fiscal impact.

OLR Bill Analysis
sHB 5154

AN ACT CONCERNING HOSPITAL FINANCE AND DATA REPORTING

SUMMARY:
This bill makes several changes concerning financial and other data hospitals report to the Office of Health Care Access (OHCA). It (1) repeals the hospital net revenue system and related provisions; (2) extends the deadline by which short-term acute care and children's hospitals must submit their budgets to OHCA; (3) standardizes data reporting required of specialty hospitals; (4) expands submission requirements concerning hospital finances, employee salaries, and related entity information; (5) requires payers to file discount agreements with the hospital's business office instead of OHCA; and (6) makes several technical changes.

EFFECTIVE DATE: July 1, 2002

REPEAL OF HOSPITAL NET REVENUE SYSTEM

Until 1994, the Commission on Hospitals and Health Care (OHCA's predecessor) had to approve hospitals' rates. PA 94-9 allowed hospitals to determine their own rates or charges without OHCA's approval. OHCA instead authorized a net revenue limit for the hospital, which was its total net revenue divided by the number of equivalent discharges. Under this net revenue system, hospitals must report their budgets to OHCA, based on the rate-setting formula that existed in 1994. The bill repeals the net revenue system.

REVISED BUDGET DATA SUBMISSION DATE

Currently, acute care hospitals and children's hospitals must submit budget data to OHCA by July 1 annually for the upcoming hospital fiscal year, which begins on October 1. This bill instead requires these hospitals to submit their budgets for the next fiscal year by September 1. The submitted budget must have been approved by the hospital's governing body and include its budgeted revenue and expenses and

utilization amounts for the next fiscal year and any other data OCHA may require.

SPECIALTY HOSPITAL DATA

The bill requires specialty hospitals to submit to OHCA the same type of financial, utilization, and patient-level demographic data currently required from acute care hospitals and children's hospitals. (Specialty hospitals generally are categorized as chronic disease, substance abuse, or rehabilitation hospitals□see BACKGROUND.) Currently, specialty hospitals are not required to submit such data on any regular basis. The data is required only when a facility seeks a significant rate increase in one year or a major certificate of need authorization.

Under the bill, a specialty hospital must report to OHCA on its operations in the preceding fiscal year within five months of the close of its fiscal year. OCHA can adopt regulations specifying the form of reporting.

EXPANSION OF HOSPITAL SUBMISSION REQUIREMENTS

The bill expands hospital-reporting requirements concerning finances, personnel, and related entities and applies them to specialty hospitals.

Under current law, acute care and children's hospitals must (1) report the average salaries of administrative, supervisory, and direct service personnel in each department, by job classification; and (2) salaries and fringe benefits for the 10 highest paid positions. The bill expands these reporting requirements by requiring the salaries and fringe benefits for each of the 10 highest paid administrative, and the 10 highest paid clinical professionals, by individual position titles.

Current law requires these hospitals to report the name of each hospital-related corporation, joint venture, partnership and subsidiary. The bill expands this by requiring the full legal name of each hospital-related joint venture, partnership, subsidiary, parent corporation, or other legal entity related to the hospital, and an explanation of the relationship.

Finally, current law requires reporting of salaries paid to hospital employees by each related entity and by the hospital to employees of these related entities. The bill requires reporting of individual salary

and fringe benefits that each related entity pays for each of the hospital's top 10 administrative or clinical positions and listed by hospital position, affiliate name, and affiliate position title. (For related entity reporting, the top 10 administrative or clinical positions must be reported; for hospital position reporting (see above) the bill specifies the top 10 administrative and clinical positions.)

DISCOUNT AGREEMENTS

Currently, hospitals must file with OHCA any payer discount, alternate method of payment, or alternate schedule of price agreements. Once filed, these agreements are trade secrets and may not be disclosed. The bill continues to allow payers to negotiate with hospitals for different rates or methods of reimbursement but, as of July 1, 2002, no longer requires that they be filed with OHCA. Instead, it requires that these agreements be on file with the hospital's business office within 24 hours after their execution. An agreement between the hospital and payer is not effective until it is complete and on file at the hospital. It must be available to OHCA for inspection or be submitted to the office upon request for at least three years after the end of the applicable fiscal year.

REPEALED SECTIONS

The bill repeals several statutory provisions on obsolete budget and net revenue system procedures and obsolete specialty hospital rate setting procedures. These are: specialty hospital rate setting and requests for approval of lesser increases (§ 19a-635 and 636); hospital budget calculations for hospital fiscal year 1993 (§ 19a-655); and obsolete net revenue system provisions addressing adjustments to orders (§ 19a-660), net revenue limit (§ 19a-674); filings for partial or detailed budget review (§ 19a-675), compliance with authorized revenue limits (§ 19a-676a), inflation factor (§ 19a-678), and net revenue limit interim adjustment (§ 19a-680).

BACKGROUND

Specialty Hospitals

The specialty hospitals this bill affects are the Connecticut Childbirth and Women's Center (Danbury); the Connecticut Hospice (Branford); Gaylord Hospital (Wallingford); Hall-Brooke Hospital (Westport); Hebrew Home and Hospital (West Hartford); Hospital for Special Care

(New Britain); Masonic Geriatric Healthcare Center (Wallingford); Natchaug Hospital (Mansfield Center); the Rehabilitation Hospital of Connecticut (Hartford); St. Francis Care Behavioral Health (Portland); Silver Hill Hospital (New Canaan); and Stamford Rehabilitation Hospital (Stamford).

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 24 Nay 0